CASE NO. 80–1690

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IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1981

AMERICAN MEDICAL ASSOCIATION,
Connecticut State Medical Society,
New Haven County Medical Association, Inc.,
Petitioners,

v.

FEDERAL TRADE COMMISSION,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE STATES OF OHIO, ARIZONA, COLORADO, CONNECTICUT, IOWA, MARYLAND, MINNESOTA, NEBRASKA, NEW MEXICO, NEW YORK, NORTH CAROLINA, PENNSYLVANIA, RHODE ISLAND, AND WEST VIRGINIA AS *AMICI CURIAE* IN SUPPORT OF THE FEDERAL TRADE COMMISSION

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INTEREST OF THE *AMICI* STATES

The *amici* states have a direct and substantial interest in the case in both their sovereign and proprietary capacities. The attorneys general of the states are responsible for the enforcement of their respective state antitrust laws and are authorized to represent the interests of their states and citizens *parens patriae* under the federal antitrust laws. *See, e.g., Georgia v. Pennsylvania R.R. Co.,* 324 U.S. 439 (1945) and 15 U.S.C. Section 15(c). The state attorneys general can also represent their states and local governments in proprietary

actions for damages under state and federal antitrust laws. *See, e.g.,* 15 U.S.C. Sections 15 and 26.

The AMA's anticompetitive ethical restrictions directly affect the *amici* states in their proprietary and sovereign capacities. The states spend billions of dollars annually for health care services, e.g., under their Medicaid programs for the poor and through health insurance premiums for their employees. The citizens of the states, both consumers and providers, are adversely affected by the AMA's ethics that restrict and impede a private market for health care services.

STATEMENT OF THE CASE

A. Background

Between 1970 and 1980, the nation's health care bill more than tripled to nearly $250 billion, and in the next ten years it is expected to triple again. Freeland, Calat & Schendler, *Projections of National Health Expenditures, 1980, 1985 and 1990,* 2:3 Health Care Financing Rev. 1, 2-4 (1980). Federal, state and local governments have seen their expenditures for needed health care services rise nine fold between 1965 and 1980, from $11 billion to $101 billion. *Id.* at 2. Between 1965 and 1980, private spending skyrocketed from $32 billion to $144 billion. *Id.* In 1980 alone, the nation spent approximately $50 billion on physician services, or about 20% of the nation's total health expenditures. Another 40%, or $100 billion, was spent on hospital services, most in response to physician direction. *Id.* at 1.

Against this background, the Federal Trade Commission filed the complaint in this action in December, 1975. The complaint charged that the "[r]espondents and others have agreed to prevent or hinder competition between medical doctors" through the *Principles of Medical Ethics. In re American Medical Assn.,* 94 F.T.C.

701, 703 (1978). The application of the challenged ethical principles over time has contributed in significant measure to the ever escalating costs of health care in the United States.

The contract practice, advertising and solicitation ethics with which this case is concerned are overlapping, broadranging and long standing. 94 F.T.C. at 808-911, 1002-18. Of the three, the contract practice ethics are the most profound, and merit careful elaboration.

B. The AMA's Contract Practice Ethics Defined

As the name suggests, contract practice ethics govern the contractual arrangements a physician might enter to render medical services, including contracts with hospitals, insurers, health maintenance organizations, health plans, employers, unions and non-physician providers. Section 6 of the AMA's *Principles of Medical Ethics* at the time of suit defined "contract practice" simply and broadly in the following terms:

> A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

94 F.T.C. at 896, 1011. The record reveals that the contract practice ethics date back as early as 1912:

> It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community.

94 F.T.C. at 1011 n. 59.

The AMA's actual interpretation of its amorphous contract practice ethics in effect at the time of suit and dating back to 1927 essentially made it unethical for a physician to enter a contract that generated competition among doctors over price and efficiency:

> Opinion 3 of Section 6 of the *Opinions and Reports* lists several contractual restrictions that are unfair or unethical. These are:
>
> (1) When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.
>
> (2) When the compensation is so low as to make it impossible for competent service to be rendered.
>
> (3) When there is underbidding by physicians in order to secure the contract.
>
> (4) When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.
>
> (5) When there is solicitation of patients directly or indirectly.

94 F.T.C. at 1012. (For a comprehensive collection of the AMA's positions through 1959 on contract practice, including Item (4) "free choice", *see* AMA, *Report of Commission on Medical Care Plans,* J.A.M.A., Special Edition (Jan. 17, 1959), part II at 117-26 (*"Larson Report"*.)

Of all the contract practice ethics' provisions, "free choice" is the most deceptive. "Free choice of doctor" is one of those brilliant phrases that sounds so good and wholesome that few people have ever stopped

to examine what it really means and how it is actually used. The Commission's analysis, concluding that the purpose of the AMA's "free choice" provision "is primarily the anticompetitive one of suppressing the activities of competitors, not solicitude for the rights of patients", is one of the few critical analyses available. 94 F.T.C. at 1015. *See also* A. Somers & H. Somers, *Doctors, Patients, and Health Insurance* 409-13 (1961) ("Somers & Somers") & A. Enthoven, *Health Plan* 77 (1980).

"Freedom of choice" is ironically an essential element of both the AMA's and the private market model of medical care. The differences between market "free choice" and the AMA's "free choice" are profound.

The AMA's "free choice" ethics mean that *each* doctor must be allowed to participate in *each* health plan or other insurance arrangement. The AMA's Judicial Council has declared that "free choice of physician...expressly requires that any qualified licensed physician residing in the area in which the plan operates be allowed to participate". 94 F.T.C. at 903. In the Commission's terms:

> [This] ethical restriction has had the effect of impairing competition from alternative providers in the medical service market by discouraging use of innovative arrangements that can deliver services at lower cost.

Id. at 1015. At bottom, the AMA's version of "free choice" was and is intended to eliminate "cut throat price competition" among physicians through insurance, as a 1939 AMA publication admitted:

> In place of what is essentially "cut-throat price competition" that has so frequently demoralized business, the medical profession has substituted the requirement that

> there be reasonable competition among qualified physicians. Therefore, the organization of a medical care plan which gives a few physicians a monopoly on the provision of medical services for members by it denying those members the right to choose their own physicians from among all qualified physicians in the community has been opposed by the stipulation in the "Principles of Medical Ethics" that there must be no interference with reasonable competition in a community.

AMA, *Organized Payments For Medical Services* 142 (1939). "Reasonable competition among qualified physicians" is used here synonymously with the AMA's "free choice" provision, as shown by the 1912 contract practice ethics. *See, e.g.,* 94 F.T.C. at 1011 n. 59.

Under market "free choice", consumers have a right to choose between competing groups of providers (health plans) and traditional insurers on the basis of price, quality and benefits. *See* Appendix A, part B. Consider, for example, a medical community that is divided into three distinct groups, each affiliated with an insurance arrangement called a health plan. Assume for simplicity that there is only one conventional insurer, where the consumer can go to any physician in the community and be indemnified up to the "usual, customary and reasonable" fee. Under *market* "free choice", consumers can choose any of the health plans or the conventional insurer on the basis of their differing premiums, quality and other factors. Consumers can freely choose their doctor either at the time they select a health plan or, if they choose traditional insurance, at the time they go to see the doctor. Under private market "free choice", each health plan's affiliated doctors have incentives to perform efficiently because their health plan's premiums can then be lower and benefits broader.

By contrast, under the AMA's "free choice" ethics, each health plan is unethical because it excludes, in the example, two-thirds of the qualified licensed physicians in the community. Health plans, which create incentives for their physicians to perform efficiently, are what the medical profession terms "closed panels". As the AMA's Maryland affiliate affirmed in 1967, "the closed-panel practice of medicine...[is] an abridgement of 'freedom of choice'". 94 F.T.C. at 903.

Thus, contrary to the ordinary meaning of the words "free choice", under the AMA "free choice" consumers have been and are denied the right to freely choose competitive groupings of doctors and insurance called health plans. Under the AMA's "free choice", no matter which insurer a consumer chooses, every doctor is included. Provider price competition over premiums and efficiency is lost and the patient has no incentive to switch from inefficient providers to efficient ones.

The Commission concluded that the AMA's contract practice ethics, although couched "in terms of preventing impairment of medical judgment and deterioration of medical care", in fact "bear little relation to those objectives". 94 F.T.C. at 1012.

C. The Contract Practice, Advertising and Solicitation Ethics Applied

The AMA contends this case concerns the medical profession's "evolutionary" development of ethics to combat "deception". Pet. Brief at 28. The undisputed record, on the other hand, shows these ethics reach far beyond "deception". Among other things, the findings of fact show that for over fifty years the AMA and its affiliated medical societies used their contract practice, advertising and solicitation ethics, alone and in combination, to (1) suppress contracts by physicians which

generated competition among doctors over price and efficiency; (2) restrict the availability of information concerning individual physicians and their fees; (3) prevent innovative clinics, preventive medicine programs, health maintenance organizations ("HMOs") and other alternative forms of medical care delivery from disseminating truthful information; and (4) restrict the information available to consumers in physician announcements and business or consumer directories. 94 F.T.C. at 808-911, 1002-18.

In the 1920's and 1930's, there was rapid growth in a form of health insurance entirely different from the forms that prevail today. "[T]he voluntary insurance of 1932 was not the type of voluntary insurance familiar to us today." O. Anderson, *The Uneasy Equilibrium* 100 (1958). Blue Cross and Blue Shield did not exist. Commercial insurers did not as a practical matter write health insurance. R. Eilers, *Regulation of Blue Cross and Blue Shield Plans* 13 (1963).

The form of what is now called health insurance that predominated and was growing rapidly in the 1920's and 1930's is what is now called a health plan. Hospitals and doctors were breaking into groups competing through the insurance mechanism over price (premiums), efficiency, quality and benefits:

> The real difference between all of those programs and the Blue Cross and Blue Shield was that all of the early programs provided care in a single institution under the care of a single group of physicians connected with that institution. All of those early plans were what we would now call HMOs [health plans]. There was a cooperative arrangement between a group of physicians, an institution and a financing mechanism.

Recipient of the 1974 Justin Ford Kimball Award, 46 Hospitals 68, 71-72 (July 16, 1972). *See also* P. Williams, *The Purchase of Medical Care Through Fixed Periodic Payment* (1932) & Leland, *Contract Practice,* 98 J.A.M.A. 808 (March 5, 1932) (Director of the AMA's Bureau of Medical Ecomonics).

The health plans that were forming in a competitive market were generating price competition over "premiums" and efficiency among groups of doctors and hospitals. In 1933 the AMA House of Delegates endorsed a report that proscribed these plans as "contract practice schemes":

> One of the pernicious effects of contract practice schemes is that each of them stimulates the launching of other similar schemes until there are many in the field competing with each other. The first may have safeguards against many of the abuses of contract practices, but as new ones are formed the barriers are gradually broken down in order to secure business.

94 F.T.C. at 1013.

The AMA and its affiliated societies vigorously used the contract practice, advertising and solicitation ethics to suppress the "health plan" form of health insurance. For instance, in 1936, the AMA's Judicial Council, contrary to an assertion in the *AMA Brief*[1], enforced the

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1. The AMA Brief erroneously states that "the Judicial Council had approved physician advertising and contract practice in the only instance in which it considered these issues in the context of a specific case". Pet. Brief at 9 n. 7. A second example of Judicial Council enforcement of the contract practice, advertising and solicitation ethics in the context of a specific case is found at 94 F.T.C. 899. The AMA was also criminally convicted for using its contract practice ethics to suppress a health plan in *American Medical Assn. v. U.S.,* 317 U.S. 519 (1943). The private enforcement of private law is classic cartel conduct. *See, e.g., Fashion Originators' Guild of America v. FTC,* 312 U.S. 457 (1941).

ethics against several physicians affiliated with a proposed health plan for International Harvester employees in Wisconsin. 94 F.T.C. at 899. Similar action led to the AMA's criminal conviction under the antitrust laws in 1943. *Id.* at 899-900 & *American Medical Assn. v. U.S.*, 317 U.S. 519 (1943).

Over the next few years, the tide began to change as the AMA, its affiliates and others suppressed competitive health plans through the vigorous application of the AMA's contract practice, advertising and solicitation ethics. As an AMA Bureau of Medical Economics study boldly reported:

> *The result of the position taken by medical societies and by hospital administrators in sympathy with medical ethics was to bring gradually into disrepute those plans which did not follow the more essential principles that have been outlined.* New plans promoted by commercial agencies or profit-seeking promoters no longer appealed to hospital administrators. *The day of the commercial and competitive schemes began to wane* and in their stead rose the city-wide, noncommercial associations of hospitals designed to offer hospital facilities on a prepayment basis.

AMA Bureau of Medical Economics, *Group Hospitalization* 41 (1937) (emphasis added).[2]

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2. *See* 94 F.T.C. at 898-907. *See also* Note, *American Medical Association: Power, Purpose, & Politics*, 63 Yale L.J. 937, 976-96 (1954); A. Somers & H. Somers, *Doctors, Patients, & Health Insurance*, 261-340 (1960); *American Medical Assn. v. U.S.*, 317 U.S. 519 (1943); M. Davis, *America Organizes Medicine* (1941) & E. Rayack, *Professional Power and American Medicine* (1968).

The contract practice ethics, in addition to being used to suppress health plans, were being incorporated in the profession's own health insurance plans, Blue Shield for medical care and Blue Cross for hospital care, beginning in 1933:

> [I]n 1933, the next stage of the movement toward some form of health insurance was on its way. The chief providers of services, hospitals and physicians, had been heard from. They had declared themselves in favor of some form of voluntary health insurance if sponsored, initiated, and controlled by the respective representatives of the hospital and medical associations.

O. Anderson, *The Uneasy Equilibrium* 104 (1958). The AMA's "Blue Shield concept", the undisputed factual findings show, included "freedom of choice of physician" as well as "acceptance of leadership by the medical profession". 94 F.T.C. at 753.

The AMA contends its contract practice ethics, including "free choice", are "archaic statements, made in response to conditions existing in the 1920's and 1930's ...". Pet. Brief at 5. The undisputed record shows that the contract practice ethics, often in conjunction with the advertising and solicitation ethics, continued to be vigorously applied through the 1970's and after the *Goldfarb* decision. 94 F.T.C. at 808-911, 1002-18; *Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975) (*"Goldfarb"*).

First, the ethical restrictions continued to be enforced to suppress health plans and thus provider competition over price and efficiency. For example, the Harvard Community Health Plan, from 1969 until after this suit was filed, had continuing restrictions placed on its advertising. 94 F.T.C. at 833. From 1970 through

December, 1976, a year and a half after *Goldfarb*, the Arizona Health Plan was harassed because it was "no different than a Kaiser-type closed-panel system and was 'unacceptable' to organized medicine". *Id.* at 830. In December, 1976, the New Haven County Medical Society disparaged HMOs as "socialized medicine" – eighteen months after *Goldfarb*. *Id.* at 908-09. The ethics were used to undercut the operation of the Florida Health Care Plan throughout the 1970's. *Id.* at 829-30, 906. As late as June, 1977, two years after *Goldfarb*, doctors affiliated with the Plan continued to be harassed – just as doctors affiliated with health plans have been for over fifty years. *Id.*

Second, the contract practice, advertising and solicitation ethics live on in corporate form. Most Blue Shield plans continue to be controlled by local medical societies. *See* F.T.C. Bureau of Competition, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Prepayment Plans* (April, 1979). They continue to be incorporated in medical society Foundations for Medical Care. 94 F.T.C. at 753, 787, 796. *See also Arizona v. Maricopa County Medical Society*, 643 F.2d 553 (9th Cir., 1981), *cert. granted*, Case No. 80-419 (March 9, 1981).

D. The AMA's Contract Practice Ethics That Remain After *Goldfarb*

The AMA contends that, after *Goldfarb*, it "deleted archaic positions on contract practice ...". Pet. Brief at 7. In fact, the AMA's own documents show that the contract practice ethics remain essentially unchanged to this day, six years after *Goldfarb*.

The contract practice ethics were untouched by the April, 1976 AMA statement on advertising and solicitation (ten months after *Goldfarb*). Pet. Brief at 6-7.

The 1977 and 1981 editions of Judicial Council *Opinions* do not delete the contract practice ethics. They revert to *broad* statements similar to the original *Principles of Medical Ethics.*

The vague language the AMA quotes (Pet. Brief at 7) from the 1977 edition is essentially the same as Section 6 of the *1971 Principles:*

1971 Edition

> Section 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

J. App. at 29. *See also* 94 F.T.C. at 1011.

1977 and 1981 Editions

> [Physicians] should not be subjected to lay interference on professional matters and...their primary responsibility should be to the patients they serve.

J. App. at 80-81; 1981 edition Section 8.05.

The language the AMA quotes from the 1977 edition, moreover, is *not* the only contract practice language in it. The AMA's "free choice" and other aspects of the contract practice ethics addressed in the Federal Trade Commission opinions, such as physician relations with hospitals and non-physicians (94 F.T.C. at 1011-18), are also the subject of vague statements in the *1981 Opinions. See,* Appendix B.

E. The Cease and Desist Order Before The Court

The AMA argues that the FTC's order is "sweeping" and "undermines responsible professional self-regulation in the public interest". Pet. Brief at 11, 40. The actual Order before the Court, however, is limited to enjoining the anticompetitive practices the AMA and its affiliates have persistently engaged in over a fifty year period under the guise of contract practice, advertising and solicitation ethics. *See* Appendix C.

As procedural matter, the original Order issued by the administrative law judge, 94 F.T.C. at 975-77, was amended and narrowed twice, first by the Commission, 94 F.T.C. at 1036-40, and second by the Court of Appeals for the Second Circuit, 638 F. 2d at 452-53.

The AMA's advertising and solicitation ethics are the subject of Part I of the Order before this Court. However, Part I specifically reserves the right of the AMA and its affiliates to adopt and enforce ethical guidelines that specifically address first, conduct they "reasonably believe" is "false and deceptive" within the meaning of the F.T.C. Act, and second, conduct concerning certain patients who "are vulnerable to undue influence".

The AMA's contract practice ethics are the subject of Part II of the amended Order.

Finally, Part IV(D) assures that the AMA's affiliated societies adhere to the Order by use of the rather unobtrusive disaffiliation procedure utilized in *U.S. v. National Society of Professional Engineers,* 1978-2 CCH Trade Cas. Para. 62,226 (D.C.D.C. 1978).

SUMMARY OF ARGUMENT

I.

The Federal Trade Commission has jurisdiction over the American Medical Association under Section 4 of the FTC Act, 15 U.S.C. Section 15. The AMA is a non-profit trade or professional association representing the business of for-profit physicians. The AMA concedes the FTC has jurisdiction over non-profit trade associations of "traditional business entities". The AMA argues that Congress intended to limit Section 4 to the "traditional business entities" of 1914. Neither the language of Section 4 nor national policy favoring private competitive markets provide any support for the AMA's attempt to freeze the FTC Act to 1914 patterns. *See Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975). Whatever the ultimate reach of Section 4 may be over non-profit corporations, the FTC has jurisdiction over the American Medical Association.

II.

The Federal Trade Commission and Court of Appeals' decisions correctly hold that the AMA has engaged in serious trade restraints that will continue to undermine private market incentives for quality and efficiency unless an effective injunctive order is in place.

The undisputed findings of fact show that for over fifty years the AMA and its affiliated medical societies applied their vague contract practice, advertising and solicitation ethics, alone and in combination, to (1) suppress contracts by physicians which generated competition among doctors over price and efficiency; (2) restrict the availability of information concerning individual physicians and their fees; (3) prevent innovative clinics, preventive medicine programs, health maintenance organizations and other alternative forms of medical care delivery from disseminating truthful information; and (4)

restrict the information available to consumers in physician announcements and business or consumer directories. In nature and duration, the AMA's ethical restrictions are comparable to the price-fixing and market division agreements disapproved in *Timken Roller Bearing Co. v. U.S.*, 341 U.S. 593 (1951); *U.S. v. Imperial Chemical Industries, Ltd.*, 100 F. Supp. 504 (S.D.N.Y. 1951) and *U.S. v. Paramount Pictures*, 334 U.S. 131 (1948).

The essential guild features of the AMA's contract practice, advertising and solicitation ethics are deeply rooted and have never been abandoned – not after the AMA's criminal conviction in 1943; not after historic language changes in 1959; not after this Court's *Goldfarb* decision, and not even to this day. Remarkably, the AMA's *1981 Opinions* in key provisions are a step backward to the vague and broad ethical pronouncements prevailing at the turn of the century rather than a step forward to specific guidelines consistent with this Court's decision in *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

The actual Order before this Court is a narrowly targeted order that surgically removes guild practices which obstruct the achievement of private market reform in the health care field for the first time in this century. Accordingly, the decision of the Court of Appeals should be affirmed.

ARGUMENT

I. THE FTC HAS JURISDICTION OVER A PROFESSIONAL ASSOCIATION REPRESENTING PHYSICIANS CONDUCTING FOR–PROFIT BUSINESSES.

This case does not test and this Court need not decide the ultimate reach of the FTC's jurisdiction under Section 4 of the Clayton Act. 15 U.S.C. Section 15.

Section 4 readily can and should be interpreted to provide the FTC jurisdiction over the AMA as a trade or professional association representing the for-profit businesses of physicians.

The AMA does not attempt to argue, and could not, that its physician members are eleemosynary institutions. Physicians annually earn $50 billion, and about 60% of them are AMA members. 94 F.T.C. at 709. Physicians are for-profit businesses, as indicated by the AMA's successful efforts to obtain tax relief for self-employed and professional corporation physician members under the Keogh Act. 94 F.T.C. at 748.

The AMA concedes, as indeed it must, that Congress intended Section 4 to give the FTC jurisdiction over antitrust violations by "non-profit" trade associations of industrial and commercial businesses. Pet. Brief at 26 n. 20, 27 n. 21.

The AMA tries to distinguish itself from industrial trade associations by arguing, first, that Congress intended to limit the FTC Act to "traditional business entities" and second, "trade associations of manufacturers or dealers have little other purpose than profit maximization ...". Pet. Brief at 17-21, 26n. 20. Neither argument has any merit.

First, the language of Section 4 is not limited to "traditional business entities". Accordingly, the same policy considerations that led this Court to unanimously reject a "learned professions" exemption from the Sherman Act, 15 U.S.C. Section 1, apply to the FTC Act of 1914, which promotes the same fundamental national policy favoring private competitive markets. *Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975).

Second, the language of Section 4 nowhere uses the *solely* profit maximizing purpose test the AMA in effect advances. Indeed, such a test is not workable. Any trade

or professional association could escape FTC jurisdiction over antitrust violations by devoting some or even most of its activities to other than profit maximizing activities. Indeed, the most successful cartels would most easily escape the FTC's jurisdiction, since its members with their monopoly profits could best afford the biggest dues for such activities.

Accordingly, it is sufficient for the present case to hold that the FTC has jurisdiction over trade and professional associations representing the for-profit businesses conducted by physicians. The NAACP, the Smithsonian Institution, and Yale University are *not* trade or professional associations. *Cf.* Pet. Brief at 27. Whether any one of them is "organized to carry on business for its own profit or that of its members" and the ultimate reach of the FTC's jurisdiction under section 4 is simply not before the Court.

II. THE FEDERAL TRADE COMMISSION OPINIONS DOCUMENT SERIOUS ANTICOMPETITIVE PRACTICES BY THE AMA THAT WILL CONTINUE UNLESS THE ORDER IS AFFIRMED

A. The FTC Opinions, If Anything, Understate the Persistent Anticompetitive Impact of the Contract Practice, Advertising and Solicitation Ethics

The Federal Trade Commission opinions at both the administrative law judge and Commission levels provide an invaluable service to the public, the medical profession and the entire health care industry. Both opinions apply a balanced Rule of Reason analysis to the complex and unique facts of the nation's $250 billion health care industry. These opinions provide a model antitrust analysis that can be used by both courts and counsel in evaluating the antitrust consequences of conduct in the

health field. In addition, these opinions provide a compelling and unique analysis of American medicine from the perspective of the competitive policy of the nation's antitrust laws. That analysis, replete with example after example of guild conduct right up to present times, provides a powerful prologue for the future if the FTC's fair and reasonable order is not upheld.

Eliminating provider competition over prices and efficiency is the central purpose of the specific AMA ethical prohibitions involved in this case. The AMA's contract practice (including free choice), advertising and solicitation ethics are not merely "ethical guidelines to combat deception", Pet. Brief at 28, that serve the public in the proud and vital tradition of professional self-regulation. Instead, the FTC's undisputed factual findings reveal pervasive guild agreements. As the AMA stated more than forty years ago, "it clung. . .to the guild form of organization" and considered itself "responsible for the amount of production, for prices and for the competitive relations of. . .[its] members". AMA, *Economics and the Ethics of Medicine* 8 (1936) & AMA, *An Introduction to Medical Economics* 19 (1933). (*See also* the testimony of Dr. Robert Ebert, *J. App.* 307, 324-25). The AMA has used the broad language of its contract practice (including free choice), advertising and solicitation ethics to govern price, production and competitive relations among physicians for many years. 94 F.T.C. at 808-911, 1002-18. In the revealing testimony of an AMA official at trial, "it would be inappropriate for physicians to compete with other physicians on the basis of price, quality and service...". *Id.* at 1007.

Not only have advertising and solicitation by physicians been restrained, but under the long established contract practice provisions, doctors are barred from entering agreements with consumers, employers, unions, insurers, hospitals and health plans that pay less than "usual fees", involve "underbidding", are not open to any interested physician (so-called "free choice"), use

alternatives to fee-for-service compensation, or employ non-physician arrangements that "may be more economically efficient business formats". *Id.* at 1002-18. The AMA's ethics suppress the very provider price competition necessary for private markets to perform effectively. As the Commission concluded:

> [I]t is evident from a facial examination of AMA's ethical provisions and from evidence concerning adoption of these restraints that they are *designed to limit price competition among doctors.*

Id. at 1014 (emphasis added).

The ethics were and are used to suppress health plans that pluralistically divide the medical community into groups competing through an insurance mechanism over quality and efficiency. *See,* 94 FTC at 896-911 & Appendix A. They were and are used to keep hospitals from integrating into medical markets. *See, e.g.,* 94 FTC at 905. (Note also the general pattern of hospital-controlled Blue Cross plans covering hospital care, but not medical care, and physician-controlled Blue Shield plans covering medical care but not hospital care. O. Anderson, *Blue Cross Since 1929* (1975) & Somers & Somers, *supra,* Chaps. 15-16). They were and are used to segregate the insurance market from medical and hospital markets, by blocking insurers and health plans from contracting with doctors for less than "usual fees" or with less than all interested physicians in the community (AMA "free choice"). 94 FTC at 869-911. They were and are incorporated into the AMA's and its affiliates' own insurance arrangements, Blue Shield plans and Foundations for Medical Care. *Id.* at 753. The incorporation of cartel agreements in corporate form is reminiscent of *Timken Roller Bearing Co. v. U.S.,* 341 U.S. 593 (1951). *See also U.S. v. Paramount Pictures,* 334 U.S. 131 (1948) (industry pattern of price-fixing joint ventures).

In important aspects, the AMA's contract practice, "free choice", advertising and solicitation ethics are horizontal market sharing agreements. The overall purpose and effect of these ethics, particularly on the prepaid market for hospital and medical care, is a perverse system where provider accountability is separated and fragmented: doctor from doctor, doctor from hospital, insurer from both. Provider efficiency, or inefficiency, is eliminated as an element of consumer choice. This result is the ultimate goal of all horizontal market sharing agreements, a self-contained market for each seller:

> Detriments from market division depend, we discern, upon the extent to which self-contained markets insulated one from another are attained. . . .[T] o the extent that by agreement sellers do successfully entrench themselves each in a separate market, the damage to competition is likely to be even more devastating than that consequent upon price fixing.

L. Sullivan, *Handbook of the Law of Antitrust* 225-26 (1977). *See St. Paul Fire & Marine Ins. Co. v. Barry*, 443 U.S. 531, 533 n. 25 (1978).

The FTC opinions document one of the longest lasting, most deeply embedded and farthest reaching aggregations of trade restraints in American antitrust jurisprudence. They have a profound impact not only on the $50 billion market for medical services, but much of the $250 billion health care industry which constitutes the third largest and one of the most inflationary sectors of the American economy. In nature and duration, they are analogous to *Timken Roller Bearing Co. v. U.S., supra* (1951 decision reaching cartel agreements dating from 1909) and *U.S. v. Imperial Chemical Industries, Ltd.*, 100 F. Supp. 504 (S.D.N.Y. 1951) (decision involving cartel agreements dating from 1897). The central dilemma for the AMA's guild model

is that without provider price competition the guild model has no internal incentives for doctors and hospitals to perform efficiently and thus invites government intervention to correct serious market failure. The central issue in this case is whether medical care will continue to be governed by medical guilds, or whether the public and the profession will be freed from the guild model to develop a private market with its self-correcting incentives for quality and efficiency. To this extent, the decision for this Court parallels its decision in *Schechter Poultry Corp. v. U.S.*, 295 U.S. 495 (1935), where the Court rejected private government by business guilds.

B. The AMA's Post–*Goldfarb* Conduct Underscores The Need For An Effective Order

The conduct of the AMA and its affiliates after *Goldfarb*, coupled with their conduct before June, 1975, overwhelmingly establishes the need for an effective order. The essential guild features of the contract practice, advertising and solicitation ethics have never been abandoned – not after the AMA's criminal conviction in 1943; not after the wording changes based on the AMA's *Larson Report* in 1959; not after this Court's *Goldfarb* decision; and not even after the complaint in this case was filed. The AMA's mootness, abandonment and similar arguments are meritless diversions from the applicable law and facts.

The test the AMA must meet to establish mootness or abandonment is strict. *U.S. v. Concentrated Phosphate Export Assn.*, 393 U.S. 100 (1968) & *U.S. v. W.T. Grant*, 354 U.S. 629 (1953). The AMA has not and cannot show "there is no reasonable expectation that the wrong will be repeated". *U.S. v. W.T. Grant*, 345 U.S. at 634. The AMA ethics at issue are firmly settled and continuing abuses.

First, the AMA and its affiliates did not abandon their subtle and not so subtle enforcement of the contract practice, advertising and solicitation ethics after their criminal conviction in *American Medical Assn. v. U.S.*, 317 U.S. 510 (1943), as the repeated examples of their post-1943 enforcement cogently attest. 94 F.T.C. at 808-911, 1002-18.

Second, the AMA in its post-*Goldfarb* contract practice revisions chose to backslide into broad and vague language, rather than follow the approach adopted by this Court in *National Society of Professional Engineers v. U.S.*, 435 U.S. 679, 699 (1978), of developing "some other ethical guideline more closely confined to the legitimate objective[s]". *See* Appendix B.

Third, the AMA and its affiliates did not abandon the anticompetitive *application* of their "free choice" ethics after they made historic and laudatory *language* changes in the "free choice" ethics in June, 1959. Since the *1981 Opinions* "free choice" language is materially unchanged from the June, 1959 version, the anticompetitive conduct by the AMA and its affiliates from 1959 through trial can reasonably be expected to be the pattern of their future conduct, unless an effective order is entered in this case.

Professors Somers and Somers described the historic change in the AMA's "free choice" language in their invaluable book, *Doctors, Patients, and Health Insurance* 355 (1961):

> ...[T]he official AMA policy with respect to closed panel practice underwent a far-reaching change. Its longstanding opposition to this type of health insurance, primarily in the name of "free choice," was abandoned in favor of the flexible policy set forth in the Larson Report

> recommendations adopted by the House of Delegates in June, 1959, . . . that the individual should have free choice of either his physician or his medical plan.

The specific language, based on the *Larson Report*, is contained in an AMA interpretation of its "free choice" ethics adopted in June, 1959, in a simple clause referring to "preferred system of medical care":

> FREE CHOICE OF PHYSICIAN
>
> The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses;
>
> Each individual should be accorded the privilege to select and change his physician at will *or to select his preferred system of medical care* and the American Medical Association vigorously supports the right of the individual to choose between these alternatives:
>
> Lest there by any misunderstanding, we state unequivocally that the American Medical Association firmly subscribed to freedom of choice of physician and free competition among physicians as being prerequisites of optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows or abridges such freedom of choice and such competition.

AMA, *1971 Opinions and Reports*, Section 1, No. 4, CX-462L (emphasis added). *See also* Somers & Somers, *supra* at 341.

There is no material change in meaning from the AMA's "free choice" provision in 1959 and the latest *1981 Opinions:*

> 9.05 FREE CHOICE. Free choice of physicians is the right of every individual. The individual may select and change at will the physicians who serve him, or he may choose a medical care plan such as that provided by a closed panel or group practice, or he may choose to obtain medical care by becoming a subscriber of a health maintenance or service organization. The freedom of the individual to select his preferred system of medical care and free competition among physicians and alternative systems of medical care are prerequisites of ethical practice and optimal medical care.

Appendix B. This 1981 version merely gives examples, such as "closed panel or group practice", "health maintenance or service organizations" of the 1959 concept "preferred system of medical care".

The laudatory changes in the language of the AMA's "free choice" ethics in June, 1959, however, did not change the conduct of the AMA and its affiliates. From 1959 through trial, as the FTC's undisputed factual findings demonstrate, the AMA and its affiliates continued to enforce their guild "free choice" and related ethics as if the June, 1959 changes had never been made. 94 F.T.C. at 829-30, 900-07. Indeed, less than six months after the AMA House of Delegates adopted the recommendation of the *Larson Report* permitting closed panel plans, the House of Delegates changed its mind. In December, 1959, the AMA House of Delegates disapproved the concept of closed panel practice. RX 308, p. 29. *See also* 94 F.T.C. at 903. Without an effective order, the AMA and its affiliates are free to

revert to their anticompetitive language or practices no matter what the *1981 Opinions* say.

Fourth, AMA officials have taken positions this year that are virtually unchanged in words or meaning from fifty years ago. Although the positions were taken with respect to legislation proposing private competitive reforms of health care financing, they are relevant in showing the intent with which their vague *1981 Opinions* will be applied to private markets. *United Mine Workers v. Pennington,* 381 U.S. 657, 670 n. 3 (1965). Like the AMA official who testified at trial, 94 F.T.C. at 1007, these statements reveal a continuing AMA adherence to the guild model.

A recent report from the AMA's Board of Trustees, adopted by the House of Delegates, criticizes, along lines unchanged from the early 1930's, the "pro-competition" bills being considered by Congress.

> Despite some appealing aspects, "pro-competition" national health insurance bills could have some not so appealing consequences for physicians.
>
> This is the essence of a report from the American Medical Association Board of Trustees adopted by the House of Delegates at its 1981 Annual Meeting.
>
> * * *
>
> "Sponsors of insurance plans particularly under the more comprehensive competitive models, would be expected to exercise their purchasing power to control selection of providers and facilities through special arrangements with them. The availability of care to plan subscribers would be governed by such arrangements, with controls established to limit costs

> and thus create a competitive advantage," the report says.
>
> "These ends would be fostered through provider contracts, closed panel arrangements, negotiated fee schedules, and a greater reliance on large group practices, where costs theoretically could be lowered through strict internal controls," the report continues.

Competition Legislation is Criticized, American Medical News 1 (June 19 & 26, 1981). A September 18, 1981 American Medical News article, *Top AMA Leader Assails Gephardt's "Competition" Plan,* indicates the AMA favors some features of the competitive health plan proposals but conspicuously excludes the most important element – health plans:

> Specifically, the AMA favors changes in the marketplace that would:
> - Provide consumers with multiple-choice insurance options.
> - Require equal employer contribution to any plan regardless of the coverage.
> - Supply a non-taxable rebate to employes when the plan they choose costs less than the employer contribution.
> - Limit the amount of tax-deductible premium payments that the employer can claim.
> - Prohibit tax deductions for unqualified plans.

Id. at 1, 18. Without health plans and their competitive collections of doctors, the AMA's changes only perpetuate the present competition among insurers and fail to inject competition among physicians over efficiency. *See*

Appendix A. As to the seminal AMA "free choice" ethics, the February 24, 1981 Wall Street Journal quotes the AMA's Executive Vice President, Dr. James Sammons, as being "violently opposed" to any cutback in "free choice" for Medicaid patients. Schorr, *Reagan's Medicaid Plan Stirs Fears of Two-Class Health Care System,* at 25. Nothing in the record indicates the AMA and its affiliates would react any differently to changes in their "free choice" ethics for any other type of patients.

Fifth, and most important, even good faith efforts to abandon illegal contract practice, advertising and solicitation ethics are likely to fail and lead to repeated litigation because the medical profession for over 50 years has fundamentally misperceived the nature of the free market system. Guild economics reverses private market principles. Contractual arrangements with health plans and insurers that create price competition among physicians are opposed as "unfair competition" and "unethical". Contractual arrangements that eliminate physician price competition are viewed as "fair competition" and "ethical". In the medical guild model, price competition by physicians is a restraint of trade.[3]

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3. This fundamental misunderstanding of private market economics is reflected in a string of cases brought by doctors and other health professionals against participating contracts used by health plans and insurance companies. *E.g., Anderson v. Medical Service of the District of Columbia,* 551 F.2d 304 (4th Cir. 1977); *Kartell v. Blue Shield of Massachusetts, Inc.,* 592 F.2d 1191 (1st Cir. 1979); *Grigg v. Blue Cross & Blue Shield of Michigan, Inc.,* Case No. 772990 (E.D. Mich., filed Dec. 22, 1977) (physicians); Enright, *Doctors v. Blue Shield: The First Big Battle,* Medical Economics 23 (Nov. 27, 1978). *See also Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205 (1979); *Sausalito Pharmacy, Inc. v. Blue Shield of California,* 1981-1 CCH Trade Cas. Para. 63,885 (N.D. Calif. 1981) (pharmacists); *Manasen v. California Dental Service,* 1981-1 CCH Trade Cas. Para. 63,959 (N.D. Calif. 1980) (dentists); *Doctors, Inc. v. Blue Cross of Greater Philadelphia,* 557 F.2d 1001 (3rd Cir. 1976) (hospitals).

   The provider plaintiffs in these cases are alleging, in essence, that it is "anticompetitive" for an insurance company-buyer to make provider-sellers compete over price for the insurer's business and to refuse to deal with providers whose fees are too high.

Accordingly, a fair and effective injunctive order against the AMA and binding on its 2,000 affiliates at the state and local levels is essential to redress a more than half century of serious anticompetitive practices. Parts I and II of the amended Order, specifically address the anticompetitive features of the AMA's advertising, solicitation and contract practice ethics. Part IV attempts to make the order binding on the AMA's 2,000 affiliates through a disaffiliation provision. *See* Appendix C.

At the same time, the amended Order gives the AMA and its affiliates the right to address through self-regulation both false and deceptive practices as well as abusive fee practices of physicians. Specifically, Part I permits the AMA to adopt ethical standards confined to combatting any form of deception, first, that it "reasonably believes would be false or deceptive within the meaning" of the FTC Act, and second, that relates to "uninvited, inperson solicitation of actual or potential patients, who because of their particular circumstances are vulnerable to undue influence". Part II specifically permits "professional peer review of fee practices of physicians". *See* Appendix C.

Although the AMA Brief implies that the Order before this Court blocks medical societies from preventing the "terrible tragedy that can result from deceptive advertising" or from addressing "fee gouging and secret fee splitting arrangements", Pet. Brief at 10-11, it is apparent from reading the actual Order it does nothing of the kind.

Moreover, the Order before this Court in no way encroaches on the power or authority of the states, which it is the duty of the state attorneys general filing this brief to uphold. If anything, the Order enhances the authority of the states, since it is directed at private guilds that have usurped governmental powers. *Cf. St. Paul Fire & Marine Ins. Co. v. Barry,* 438 U.S. at 548-49, 553-54.

Thus, the specific remedial order before this Court is not a broad or overreaching government order that

tramples "responsible professional self-regulation in the public interest", but a narrowly targeted order that surgically removes conduct that threatens the ability of the public and the profession to achieve important private sector reforms in the health care field.

CONCLUSION

The Court of Appeals decision should be affirmed.

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APPENDIX A

BACKGROUND ON INFLATION AND THE ROLE OF PRIVATE MARKET COMPETITION IN THE HEALTH CARE FIELD[1]

A. The Underlying Cause of High Health Care Costs: The Perverse Incentives of Non-Price Competition Among Providers

Health care services in the United States are generally delivered by separate businesses such as individual physicians, hospitals and pharmacies. Notwithstanding the highly specialized and interdependent nature of modern medicine, each physician and each hospital generally bills separately for the services they provide. For example, nearly 60% of medical doctors practice alone, and 92% practice alone or in small groups. Ellwood, Malcolm & McDonald, *Competition: Medicine's Creeping Revolution* 12 (InterStudy, March 23, 1981).

Health care services are paid for both by consumers directly and by what are called "third party payors", i.e., third parties to the patient-provider relationship. In 1980, national health expenditures reached approximately $250 billion and expenditures for personal health care totalled about $220 billion. Gibson & Waldo, *National Health Expenditures, 1980,* 3:1 Health Care Financing Rev. 1 (Sept., 1981). Consumers paid about 30%, or $70 billion, of the bill for personal health care expenditures; all third parties combined – private health insurers, governments, philanthropists and industry – paid about 70% or $150 billion. *Id.* at 42.

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1. This material essentially repeats background information included in an earlier brief, Brief for the State of Ohio *Amicus Curiae* Supporting the State of Arizona at 3-6, *Arizona v. Maricopa County Medical Society,* Case No. 80-419 (1980). It is included here for the convenience of the Court.

Of the $150 billion paid by public and private third parties, private health insurers like Blue Cross-Blue Shield, Aetna, Prudential and Metropolitan paid nearly $60 billion, or about 27% of personal health expenditures. *Id.* at 1. *See generally* Carroll & Arnett, *Private Health Insurance Plans in 1978 and 1979,* 3:1 Health Care Financing Rev. 55 (Sept., 1981). Of the public third parties, Medicare and Medicaid paid over $60 billion, or 28% of personal health care expenditures. Gibson & Waldo, *supra* at 1. The table below summarizes this information:

1980		$ Billion
National health expenditures		$250
Personal health expenditures		220
1. Consumers	70	
2. Third Parties	150	
a. private insurance	60	
b. Medicare & Medicaid	60	
c. other public and private	30	
Other expenditures		30

Under the predominant forms of third party public and private health insurance, there is virtually no price competition among providers of health care services that rewards efficient doctors and hospitals. Doctors are commonly paid on the basis of what they charge under the AMA's "usual, customary and reasonable" fee device[2], and hospitals are commonly paid on the basis of costs, so that the question of the efficient use of resources does not even arise:

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2. *See, e.g.,* Roe, *The UCR Boondoggle,* 305 New England J. Medicine 41 (July 2, 1981).

> Probably the principal factor contributing to inflation has been the predominant system of third party reimbursement based on what institutions spend and what physicians charge.[3]

From the points of view of the provider and the patient, there is an apparently unlimited amount of money for health care services. Doctors, hospitals and patients are not required to set priorities, look at alternatives or make hard choices. Indeed, the present system of third party reimbursement contains perverse incentives that reward cost-increasing behavior with more revenue and punish cost-reducing behavior with less revenue. Such a system must produce inflation in prices and waste in the use of resources.

To illustrate, the efficient physician is actually punished under existing methods of reimbursement. The physician who avoids services of low or questionable efficacy, who substitutes less elaborate procedures for more costly procedures when equally effective, who

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3. HEW, *Forward Plan for Health: Fiscal Years 1980-1982* at 34 (1976). *See also* McClure, *The Medical Care System Under National Health Insurance: Four Models,* 1 J. Health, Politics, Policy & Law 22, 33 (1976); & Sen. Rep. on PL 93-141, No. 93-1285, 93d Cong., 2d Sess., 1974 *U.S. Code & Admin. News,* 7842,7878.

The analysis presented here is taken from the writings of others. *See generally* Ellwood, *Models for Organizing Health Services and Implications of Legislative Proposals,* 50 Milbank Memorial Fund Q. Part 2, 73 (Oct., 1972); McClure, *The Medical Care System Under National Health Insurance: Four Models,* 1 J. Health, Politics, Policy & Law 22 (1976); Enthoven, *Health Plan* (1980) & McClure, *Comprehensive Market and Regulatory Strategies for Medical Care* (InterStudy 1980). *See also* Havighurst, *Health Maintenance Organizations and the Market for Health Services,* 35 Law & Contemporary Problems, 716 (1970).

For the effects of provider competition in health care markets, *see* Christianson & McClure, *Competition in the Delivery of Medical Care,* New England J. Medicine 812 (Oct. 11, 1979) & *In re American Medical Assn,* 94 F.T.C. 701, 1013, 1016-18 (1978).

treats in his office instead of the hospital whenever appropriate, loses income because he or she is not paid for performing efficiently.

Physicians order services that directly or indirectly account for approximately 70% of all health care costs. Egdahl, *Fee For Service Health Maintenance Organizations,* 241 J.A.M.A. 588 (Feb. 9, 1979). The general practitioner may refer a patient to a neurologist or a surgeon, order laboratory tests and x-rays and have the patient hospitalized. Even though a physician's orders generate these costs he or she has no financial responsibility for them because each doctor or hospital is a separate firm that bills separately for their services. Thus, the physician has no incentive to seek equally effective but less costly alternatives. As a result, "most physicians don't have the vaguest notion of what things they order cost". American Medical News 9 (June 22, 1979) (quoting Dr. Darrell Cannon).

The same perverse incentives operate on hospitals. The hospital that closes excess capacity, avoids duplicative technology already located in nearby hospitals, screens out unnecessary admissions, and discharges patients as soon as medically appropriate, loses revenue because its reimbursement is based on its costs. "As any businessman knows, cost-plus is a partnership with the devil." *Health Costs – A One-Way Street,* Wall Street Journal 12 (May 8, 1975).

Similarly, it makes no difference to most patients whether they use the most extravagant doctor and hospital or the most efficient. For the vast majority of patients, insurance pays irrespective of choice. Reaping no reward, the consumer will forego the difficult effort of seeking equally effective but less costly alternatives.

Perverse incentives mean that doctors and other providers who do not restrain themselves are rewarded at the expense of those who do. Since extravagant medical care and conservative medical care are often equally medically effective but extravagant medical care is rewarded, a "spare no expense regardless of benefit" mentality develops, driving health care costs exorbitantly high – without measurable improvement in health outcomes. *See, e.g.,* V. Fuchs, *Who Shall Live?* (1974); Enthoven, *Cutting Cost Without Cutting The Quality Of Care,* 298 New England J. Medicine 1229, 1234-35 (June 1, 1978) & McNerney, *Why Does Medical Care Cost So Much?,* 282 New England J. Medicine 1458 (June 25, 1970). Unless this system is changed so that providers face incentives to be efficient, the health care industry will continue to experience unacceptably high rates of inflation.

There are basically two ways of addressing the problem of perverse incentives: government regulation, and competition. Much of the American economy, of course, uses these two basic approaches in combination, as this Court indicated in *National Gerimedical Hospital v. Blue Cross of Kansas City,* ____U.S.____, 69 L.Ed. 2d 89, 49 U.S.L.W. 4672 (June 15, 1981). *See also* P. Areeda & D. Turner, I *Antitrust Law* 133-78 (1978) (competition in regulated industries generally).

The first approach, government regulation, attempts to use public economic controls as a substitute for missing private market incentives for efficiency. Health planning agencies and hospital rate-setting commissions are classic examples of the regulatory approach. The second approach, competition, is neither well known nor well understood. It requires some elaboration.

B. The Competitive Alternative: Provider Price Competition Over Fees and Over Premiums

The private market or competitive approach seeks to establish effective market forces for doctors and other providers in the health services market. Recently there has been an increased interest among business, labor, providers and lawmakers in using "competition" as a therapy for the health care industry's feverishly high rates of inflation. *See, e.g., Competition in Health Care: Would It Bring Costs Down?,* Cong. Q. 1587 (August 4, 1979) (discussion of legislative proposals) & *Business to Support Planning Review,* American Medical News 1 (June 12, 1981).

The distinctive feature of the new market approach to health care is that it calls for *price competition* among doctors, hospitals and other providers. In the words of Paul Ellwood, M.D., the person singularly most responsible for the development of the market approach, provider price competition is essential:

> There is one awesome condition that hospitals and physicians must meet if the market is to work fully: aggregations of doctors and hospitals have to compete with each other for consumers on the basis of price.

Ellwood, *The Importance Of The Market,* 2 J. Health, Politics, Policy & Law 447, 448 (1978).

There has long been vigorous non-price competition among providers, but the new competitive approach requires what any market requires – price competition at the provider level:

> [T]he truth is that hospitals have always competed with each other in multihospital settings. The competition has been for physicians, reputation, patients, and other prizes as opposed to reduced costs, but it has been occurring for a long time. What the new market forces are provoking is a different set of competitive goals for hospitals: efficiency, appropriate utilization, cost effectiveness and innovative patterns of care.

Friedman, *Does Market Competition Belong in Health Care?*, Hospitals 47, 49 (July 1, 1980).

As this Court stated long ago, price is the "central nervous system of the economy". *U.S. v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 226 n. 59 (1940). Similarly, price competition among health care providers is central to a market solution to the health care cost problem. Recent policy analyses have identified two profoundly different ways in which providers can engage in price competition: first, over fees, and second, over premiums.

Provider price competition *over fees* seeks to introduce provider price competition when the consumer needs health care services. It generally would require changing existing health insurance coverage so that the patient pays a portion of his or her medical bill. If the consumer has to pay a portion of the bill, an incentive to select a doctor or hospital on the basis of price, among other factors, emerges.[4]

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4. An example of this approach is catastrophic health insurance. *See, e.g.*, Feldstein, *A New Approach to National Health Insurance*, 23 Public Interest 93 (1971) & McClure, *The Medical Care System Under National Health Insurance: Four Models*, 1 J. Health, Politics, Policy & Law 22, 44-47 (1980).

The second method of introducing provider price competition and incentives for efficiency is to generate provider competition *over premiums.* It starts from the premise that consumers may prefer comprehensive health insurance coverage. If all provider fees are covered, there can be no provider competition for patients on the basis of fees. Thus, the only price mechanism available is the health insurance premium itself. However, present competition over premiums is between insurers, not health care providers. Provider price competition over premiums requires distinct groups of providers who offer their services for a premium:

> [In order] to establish market forces and incentives under insurance, *providers must be split into competing groups.*

Ellwood & McClure, *Health Delivery Reform,* at 2 (InterStudy, Nov. 17, 1976) (emphasis added).

Under such a system, each group of doctors and hospitals offering their services for a premium are called "health plans" in the literature on competitive policy for health care. Health plans would compete with traditional forms of insurance, and would create choice and price competition among groupings of providers over premiums. Obviously, an efficient group of providers could have a lower premium than an inefficient group. In such systems, physicians would accept responsibility for providing comprehensive health-care services to defined populations for a prospective per capita payment, or some other form of payment that rewards economy in the use of health-care resources.

The classic example of a health plan is the closed panel health maintenance organization. It is only one of many forms that "health plans" can take, however. Other

examples include Health Care Alliances and Individual Practice Associations, as long as they do not possess undue market power because of the number of providers involved. If the number of physicians or other providers is not limited, however, price competition and its private incentives for provider efficiency are lost.

Solo fee-for-service physicians who practice high quality medicine in a conservative and efficient manner also could band together and organize a health plan. If they are efficient, then the premium for their health plan will be lower and people who choose it will receive more benefits for lower costs. On the other hand, if consumers pick providers who provide cheap and shoddy care, they would soon switch to another plan. Or, if they choose providers who are good but expensive, the plan's premium would rise and consumers could seek a more cost-effective plan.

In summary, the market approach seeks to eliminate perverse incentives, the single greatest cause of runaway health care inflation by altering the incentives so that efficiency is encouraged. By so doing, the private system can squeeze out its own excesses in a decentralized and diversified private market for health care services. Altering these perverse incentives requires the introduction of price competition among doctors and hospitals either over premiums or over fees.

The principal source of the perverse incentives that undermine the efficient performance of a private market for health care services in the United States is the widespread implementation of the AMA's contract practice ethics and other ethical prohibitions with which this case is concerned. Provider price competition is directly contrary to a guild model, and has been vigorously opposed by the American Medical Association for more than half a century.

APPENDIX B

1981 AMA Opinions Excerpts Relating to Contract Practice

3.00 OPINIONS ON INTERPROFESSIONAL RELATIONS

3.01 Nonscientific Practitioners. It is wrong to engage in or to aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient by giving him false hope, or which may cause the patient to delay in seeking proper care until his condition becomes irreversible.

* * *

3.02 Optometry. It is not unethical for an ophthalmologist to employ an optometrist as ancillary personnel to assist him provided the optometrist is identified to patients as an optometrist. A physician may send his patient to a qualified and ethical optometrist for optometric services. The physician would be ethically remiss, of course, if before doing so he did not insure that there was an absence of any medical reason for his patient's complaint, and he would be equally remiss if he sent a patient without having made a medical evaluation of that patient's condition.

Physicians may teach in recognized schools of optometry for the purpose of improving the quality of optometric education. The scope of this teaching may embrace subjects within the legitimate scope of optometry which are designed to prepare students to engage in optometry within the limits prescribed by law.

3.30 Referral of Patients. A physician may refer a patient for diagnostic or therapeutic services to another physician, limited practitioner, or any other provider of health care services permitted by law to furnish such services, whenever he believes that this may benefit the patient. As in the case of referrals to physician-specialists, referrals to limited practitioners should be based on their individual competence and ability to perform the services needed by the patient. A physician should not so refer a patient unless he is confident that the services provided on referral will be performed competently and in accordance with accepted scientific standards and legal requirements.

* * *

4.05 Physician-Hospital Contractual Relations. There are various financial or contractual arrangements that physicians and hospitals may enter into and find mutually satisfactory. A physician may, for example, be a hospital employee, a hospital-associated medical specialist, or an independent practitioner with staff privileges. The form of the contractual or financial arrangement between physicians and hospitals depends on the facts and circumstances of each situation. A physician may be employed by a hospital for a fixed annual amount, for a certain amount per hours, or pursuant to other similar arrangements that are related to the professional services, skill, education, expertise or time involved.

* * *

8.05 Contractual Relationships. The contractual relationships that physicians assume when they enter prepaid group practice plans are varied.

* * *

Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. The AMA recognizes that under proper legal authority such plans may be established and that a physician may be employed by, or otherwise serve, a medical care plan. It believes that in the operation of such plans physicians should not be subjected to lay interference on professional matters and that their primary responsibility should be to the patients they serve.

* * *

9.05 **Free Choice.** Free choice of physicians is the right of every individual. The individual may select and change at will the physicians who serve him, or he may choose a medical care plan such as that provided by a closed panel or group practice, or he may choose to obtain medical care by becoming a subscriber of a health maintenance or service organization. The freedom of the individual to select his preferred system of medical care and free competition among physicians and alternative systems of medical care are prerequisites of ethical practice and optimal medical care.

APPENDIX C

THE CEASE AND DESIST ORDER BEFORE THIS COURT

Part I of the amended Order requires the AMA to cease and desist from:

> A. Restricting, regulating, impeding, declaring unethical, interfering with, or advising against the advertising or publishing by any person of the prices, terms or conditions of sale of physicians' services, or of information about physicians' services, facilities or equipment which are offered for sale or made available by physicians or by any organization with which physicians are affiliated;
>
> B. Restricting, regulating, impeding, declaring unethical, interfering with, or advising against the solicitation, through advertising or by any other means, including but not limited to bidding practices, of patients, patronage, or contracts to supply physicians' services, by a physician or by any organization with which physicians are affiliated; and
>
> C. Inducing, urging, encouraging, or assisting any physician, or any medical association, group of physicians, hospital, insurance carrier or any other non-governmental organization to take any of the actions prohibited by this Part.

However, Part I specifically reserves the right of the AMA and its affiliates to adopt and enforce certain other ethical guidelines.

> Nothing contained in this Part shall prohibit respondent from formulating, adopting, disseminating to its constituent and component medical organizations and to its members, and enforcing reasonable ethical guidelines governing the conduct of its members with respect to representations, including unsubstantiated representations, that respondent reasonably believes would be false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act, or with respect to uninvited, in-person solicitation of actual or potential patients, who, because of their particular circumstances are vulnerable to undue influence.

Part II of the amended Order requires the AMA to cease and desist from:

> A. Restricting, regulating, impeding, advising on the ethical propriety of, or interfering with the consideration offered or provided to any physician in any contract with any entity that offers physicians' services to the public, in return for the sale, purchase, or distribution of his or her professional services, except for professional peer review of fee practices of physicians;
>
> B. Restricting, interfering with, or impeding the growth, development or operations of any entity that offers physicians' services to the public, by means of any statement or other representation concerning the ethical propriety of medical service arrangements that limit the patient's choice of a physician;

C. Restricting, interfering with, or impeding the growth, development or operations of any entity that offers physician's services to the public, by means of any statement or other representation concerning the ethical propriety of participation by non-physicians in the ownership or management of said organization; and

D. Inducing, urging, encouraging, or assisting any physician, or any medical association, group of physicians, hospital, insurance carrier or any other non-governmental organization to take any of the actions prohibited by this Part.

Part IV(D), the disaffiliation provision, of the amended Order reads:

D. Require as a condition of affiliation with respondent that any constituent or component organization agree by action taken by the constituent or component organization's governing body to adhere to the provisions of Parts I, II, and III of this Order.